TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
MEDALERT OCCUPATIONAL MANAGEMENT INC

MFDR Tracking Number
M4-17-2532-01

MFDR Date Received
April 25, 2017

Respondent Name
INDEMNITY INSURANCE CO

Carrier's Austin Representative
Box Number 15

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The documentation should sufficiently establish that one view of the ankle was completed, however due to a data entry error the modifier 52, indicating that a lesser services was provided to the patient, was not appended to the line item containing CPT 73600 X-Ray Ankle (2 views). As per AMA CPT guidelines the modifier should be used when the physician partially reduces or eliminates a service or procedure and a lesser code is not available. In this case the physician did not require a second x-ray view of the ankle."

Amount in Dispute: $65.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Respondent stands by the original denial of CPT code 73600. By definition, CPT code is to be billed when the provider performs two radiologic views of the ankle. Requestor's documentation shows they only completed one radiologic procedure of the left foot. Therefore, the documentation does not support the code billed, and no additional reimbursement is owed."

Response Submitted by: Downs Stanford, P.C.

SUMMARY OF FINDINGS

Date(s) of Service	Disputed Service(s)	Amount In Dispute	Amount Due
December 28, 2016	73600-RT	$65.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all-applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203 sets out the sets out the fee guidelines for the reimbursement of workers' compensation professional medical services provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   - 112-Service not furnished directly to the patient and/or not documented
   - P12- Workers' Compensation jurisdictional fee schedule adjustment

Issues

1. What is the AMA CPT Code description of the disputed service?
2. What are the denial reasons raised by the insurance carrier during the medical bill review process?
3. Is the requestor entitled to reimbursement?

Findings

1. The requestor seeks reimbursement for CPT Code 73600-RT rendered on December 28, 2016. 28 Texas Administrative Code §134.203 (b) states in pertinent part, "For coding, billing, reporting, and reimbursement of professional medical services, Texas workers' compensation system participants shall apply the following: (1) Medicare payment policies, including its coding; billing; correct coding initiatives (CCI) edits; modifiers; bonus payments for health professional shortage areas (HPSAs) and physician scarcity areas (PSAs); and other payment policies in effect on the date a service is provided with any additions or exceptions in the rules."

   CPT Code 73600-RT is defined by the AMA CPT Code book as "Radiologic examination, ankle; 2 views." The requestor indicates in the position summary "The documentation should sufficiently establish that one view of the ankle was completed, however due to a data entry error the modifier 52, indicating that a lesser services was provided to the patient, was not appended to the line item containing CPT 73600 X-Ray Ankle (2 views)."
2. The insurance carrier denied the disputed service with reduction code "112-Service not furnished directly to the patient and/or not documented" and "P12- Workers' Compensation jurisdictional fee schedule adjustment."

   Review of the EOBs provided by the requestor indicated the following:

   - EOB dated January 30, 2017 does not identify modifier -52 and therefore does not support that the insurance carrier audited the disputed charge and considered the -52 modifier during the medical bill review process.
   - EOB dated April 6, 2017 identifies that the requestor appended modifier -52 to the reconsideration bill and supports that the insurance carrier obtained a medical bill with modifier -52.

   28 Texas Administrative Code §133.250 states in pertinent part, "(d) A written request for reconsideration shall: (1) reference the original bill and include the same billing codes, date(s) of service, and dollar amounts as the original bill..."

   Review of the submitted documentation supports the insurance carrier's denial of "112" documentation of the billed service. The Division finds that the requestor did not submit a medical bill to the insurance carrier in accordance with 28 Texas Administrative Code §133.250 and 28 Texas Administrative Code §134.203 (b). As a result, the requestor is not entitled to reimbursement for the disputed service.
3. Review of the submitted documentation finds that the requestor is not entitled to reimbursement for disputed CPT Code 73600-RT rendered on December 28, 2016.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	May 26, 2017 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.